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Religious Identity Influence on Ethnic Minority Youth Risky Behavior

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The University of Southern Mississippi

Religious Identity Influence on Ethnic Minority Youth Risky Behavior

Laquitta Simpson

A Thesis

Submitted to the Honors College of
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of Honors Requirements

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Abstract

Previous studies have assessed religious identity in adolescents, showing that stronger religiosity correlates with lower levels of stress, better occupational and academic performances, and overall better well-being in adolescents and young adults (Koenig et al., 2001). There is also evidence of differences across races in how religiosity influences areas of adolescent behavior. The purpose of the current study is to identify the association between the strength of religiosity in White and Black at-risk youths and their involvement in risky behaviors. Data was gathered from teens aged 16-19 who are currently enrolled in a military-style residential program ($n = 80$); 57 percent of the participants were White, and 43 percent of the participants were Black. Participants answered questions regarding whether religion was important to them, whether they attended church, and how often they attended church. They also responded to a survey regarding the frequency of their marijuana use and total substance use as well as risky sexual behavior. Results from the survey indicated a negative correlation between high religiosity and involvement in risky behaviors or maladaptive coping such as self-harming behaviors for both White and Black kids. However, the importance of religion showed a stronger protective relationship in White kids while attending religious services showed a stronger protective relationship in Black kids. This provides evidence that religion has a significant association with risky behaviors displayed in adolescents, that the nature of the association varies depending on race

Keywords: Religiosity, race, risky behavior, alcohol, marijuana, military-residential style program

Dedication

My mother, Lakeyia Simpson: Thank you for consistently motivating me throughout my years in college. Words cannot express how grateful I am for you.

My grandmother, Elaine Jackson: You have kept me strong, focused, and determined to complete my education despite the numerous adversities I faced.

My closest friends, Kaitlyn, Tiara, Orianna, and Tyra: For encouraging me and reassuring me every step of the way.

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Religious Identity Influence on Ethnic Minority Youth Risky Behavior

Chapter 1: Introduction

In a busy and ever-changing society, stressors negatively impact the mental health of adolescents and young adults (Koenig & Larson, 2001). Stressors that affect these young people are often specific to their developmental stage. Today's adolescents and young adults constantly expand their knowledge of mental illnesses and learn how to identify mental health symptoms within themselves and members of their community. However, this group also experiences a sharp rise in rates of depression, anxiety, suicidal ideation, and helplessness (Gray, 2011). Additionally, different ethnic groups perceive and cope with mental health problems in different ways (Alvidrez, 1999). Even though individuals within today's society continue to develop a better understanding of mental health awareness, there are various communities that stigmatize mental illnesses. These stigmas, in turn, inhibit individuals within these communities who experience distress from receiving effective treatment.

Research suggests that Black adolescents are equally likely to experience mental and emotional distress as their White counterparts, though far less likely to utilize services for treatment (Ayalon & Young, 2005). Although racial differences have been shown to contribute to the likelihood of seeking professional mental health services, findings have also shown that mental health treatment utilization in minority communities could be due to limited access or lack of resources to utilize services (Lindsey, Brown, & Cunningham, 2017; Bryant, Haynes, Greer-Williams, & Hartwig, 2014). More than half of U.S. citizens who live in poverty are ethnic minorities. Individuals within these impoverished communities are less likely to receive psychological services due to factors such as lack of established services in their communities, lack of culturally sensitive care, or difficulty accessing services entirely (Masuda, Anderson, &

Edmonds, 2012). With this lack of mental health services, individuals in minority communities often do not receive the help they need.

Unfortunately, lack of resources is not the only structural factor to contribute to underuse of mental health resources in minority communities. Affordability of professional services also restricts individuals from receiving treatment (Alvidrez, 1999; Norquist & Wells, 1991). Even if facilities are established in disadvantaged communities, many residents would have difficulty accessing services due to the cost of medical insurance or the lack of providers accepting lower cost insurance or Medicaid. Thus, White individuals represent most of the population that utilize and receive proper treatment (Norquist & Wells, 1991).

Coping & Help-Seeking

Adolescence and young adulthood are challenging developmental stages that can involve a multitude of different stressors that influence their mental and emotional well-being (Koenig & Larson, 2001; Copeland & Hess, 1995). Both the number and magnitude of stressors may be even more extreme for adolescents who grow up in poverty (Copeland & Hess, 1995). This is especially true for ethnic minority groups in which mental illnesses may be stigmatized or poorly understood. Lindsey, Brown, and Cunningham (2017) assessed causal factors for untreated depression in Black adolescent boys and discovered that they often struggle with emotional challenges such as insecurity of masculinity, misunderstanding causes of their distress, and increasing rates in suicidal ideation. Many of the patterns in these boys were also strongly associated with less expression of distress and denial of distress, which causes mental health problems to persist if left untreated (Lindsey, Brown, & Cunningham, 2017). Professional mental health services, along with a stable support system, is generally accepted as the healthiest way to manage mental health problems; however, if minority adolescents lack the support and guidance

necessary to receive therapy or treatment, they are much less likely to seek professional help (Alvidrez, 1999).

Because professional mental health services may be viewed as problematic or unavailable in some communities (Bryant et al., 2014; Alvidrez, 1999), minority adolescents and young adults may resort to more accessible ways to alleviate stress. Rather than confiding in mental health professionals, they may be more likely to consult with family and peers who may not have much knowledge about mental health problems or the most efficient ways to cope. Additionally, minority adolescents and young adults might resort to maladaptive sources of coping such as drinking, cigarette smoking, and use of other substances (Blum et al., 2000). Studies have also shown that adolescents and young adults raised in disadvantaged communities attribute their mental health to factors such as family structure, discipline, and peers who frequently participate in risky behaviors (Blum et al., 2000; Dupere et al., 2008). Accordingly, factors such as these may contribute to those in distress being more susceptible to participate in maladaptive coping.

Religious Identity & Mental Health Perception

Although many underrepresented communities tend to lack mental health facilities, numerous research studies have observed that religious services can serve as a resource for individuals that experience mental health problems (Neighbors, Musick, & Williams, 1998). Religious sources of assistance could be helpful on their own but could also potentially serve as a collaborative factor with professional services and be used to increase mental health awareness. Individuals who reside within these communities with a strong religious network are potentially more likely to rely on their faith and gain support from fellow church members.

Religious values have also been studied as contributing factors to stigma about mental health problems in adolescents in young adults. If religious people experience mental health

symptoms, they are more likely to attribute them to external influences such as the will of God or a consequence of sin, rather than psychological causes (Ellison, Fang, Flannelly, & Steckler, 2013; Nickerson, Helms, & Terrell, 1994). Ethnic differences and the likelihood of seeking solace in religious services or clergy in place of mental health facilities have also been found (Neighbors et al, 1998; Hawes & Berkley-Patton, 2014). Out of those who rely on religious services for guidance, the prevalence of seeking help from religious services was higher among individuals within Black communities than their White counterparts (Neighbors et al, 1998). In concordance with these findings, research has also assessed how stigma influences the likelihood of Black adolescents seeking treatment from religious sources as compared to professional settings. For example, results have shown that those in the Black community may be averse to treatment due to the belief of mental health services are designed for White Americans, so professionals may not provide adequate treatment (Thompson, Bazile, & Akbar, 2004). As a result, those in the Black community were more likely to seek trusted and more informal sources, such as religious, for support.

Results have also shown that strong religious values substantially decrease the likelihood of adolescents engaging in risky behaviors (Bryant, Haynes, Greer-Williams, & Hartwig, 2014). Due to findings demonstrating a negative association between religiosity and at-risk behavior, religiosity may serve as a protective factor for youths who would otherwise be involved in risky behaviors. For example, findings have supported that adolescents who have a larger, stronger religious support system were less likely to engage in substance use such as cigarette smoking, alcohol consumption and marijuana use (Wallace et al., 2007). Studies have also examined the correlation between religiosity in African American adolescents and their likelihood to engage in risky sexual behaviors. Results show that adolescents who possessed stronger religious values,

attended services twice or more a week, and read their bible often were much more likely to engage in safe sex practices (i.e. consistent condom use) and less likely to engage in sexual activity at earlier ages (Hawes & Berkley-Patton, 2014; McKoy & Petersen, 2006)

The primary purpose of the current study is to identify how religiosity relates to involvement in risky behaviors among White and Black adolescents who are considered at-risk for negative outcomes due to difficulties with behavior and academics. We hypothesized that greater religiosity will be negatively associated engagement in risky behaviors.

Chapter 2: Methods

Participants

Participants were enrolled in a six-month, military-style program specifically intended for at-risk youths. Participants who are enrolled into the Youth Challenge Academy (YCA) have typically been referred by their parents and the program is voluntary. The YCA program is intended for adolescents who have experienced behavioral and academic issues. Participants enrolled in this program, for example, have experienced academic difficulties, have dropped out of school, have been arrested, or are unemployed. The program offers high school and college level courses as well as rigorous physical training and discipline. After the completion of the program, youths can receive their General Equivalency Diploma. The current sample consisted of 80 teens aged 16 – 19 ($M=16.77$; $SD=.742$). The majority of the participants in the study were White ($n = 46$) and the remainder were Black. ($n= 34$).

Materials

Demographic Information. Participants reported demographic data via self-reported questionnaire. Questions included those regarding their gender, age, and ethnicity.

Youth Risky Behavior Surveillance Survey (YRBSS) The number and frequency of alcohol and other drug use, as well as engagement in risky sexual behaviors, were measured with the Youth Risk Behavior Surveillance System measure (Center for Disease Control, 2015). The purpose of the YRBSS measure is to assess different potentially harmful behaviors in which youths engage. Examples of these behaviors include marijuana use, other substance use, and alcohol consumption. It also assesses the correlation between religiosity and whether participants are sexually active. For the purpose of the current study, participants' responses on the following were examined: 'During your life, how often have you had at least one drink of alcohol?', 'How often do you have at least one drink of alcohol?', 'During your life, how many times have you used marijuana?', 'How often do you use marijuana?', and 'Are you sexually active?'.

Religiosity. Each participants' religious identity and the value of religion in their lives was assessed using a measure that includes the following questions: 'Do you consider yourself a religious person?' 'Did you go to church/temple before [being admitted into the program]?' and 'How important is religion in your life?'

Procedure

Prior to administering the survey, informed consent was granted by YCA representatives and staff who have guardianship of youths while they are enrolled in the program. Information regarding the purpose of the study, benefits, and risks were then disclosed to participants. All adolescents within the program were given the option not to participate in the study. Those who chose not to take the survey were informed that they would not be penalized for their lack of participation. If an adolescent agreed to participate in the study, they provided written assent.

After assent forms were collected from adolescents who agreed to participate in our study, they were split into groups of 15-20. Participants of each group were administered a self-report questionnaire on-site at the program. Participants answered the questionnaire in groups within one of the program's classrooms on desktop computers. Estimated time of self-report survey completion was about 30 to 45 minutes. Efforts were made to minimize distractions and noise during data collection.

Chapter 3: Results

Demographic data about the sample is displayed in *Table 1*. We hypothesized that religiosity plays a substantial role in risky behaviors among adolescents. As a first step, descriptive analyses were run to see how often each racial group participated in certain risky behaviors along with measuring how many of each group both considered themselves to be religious and how many attended religious services more than once a week. There were racial differences in frequency of church attendance but not religious identification. Results shown in *Table 2* indicate that similar percentages of both racial groups--seventy-four percent of Black participants and seventy-six percent of White participants--considered themselves religious. However, when viewing frequency of service attendance, seventy-five percent of Black participants reported attending religious services more than once a week, but this was true of only approximately half of White participants. Additional results also indicate racial differences in terms of the type of risky behaviors in which youths engage. Specifically, thirty-one percent of White participants reported drinking alcohol more than once per week whereas only 13% of Black youths reported drinking at that frequency.

To determine the relationship between risky behaviors and religiosity in participants, bivariate Pearson correlations and chi square analyses were conducted between religiosity and risky behavior. These analyses were conducted for Black and White students separately. Separate chi-square analyses were conducted among White and Black youths with frequency of church attendance ($< 1\text{x/week}$ vs. $\geq 1\text{x/week}$) as one grouping factor and presence or absence of risky behaviors from the YRBSS as the other factor. These analyses revealed no significant differences in the distribution of risky behaviors across more and less religious youths in each racial group. Results are displayed in *Table 3*. The majority of participants in both groups reported a history of alcohol use, marijuana use, and sexual activity. There were no differences between the religiosity groups in relation to whether they engage in substance use or sexual activity. Bivariate correlations between the religion variables and the risky behavior variables determined that the importance of religion was negatively related to number of substances used among White participants ($r = -.35, p < .05$) but not among Black participants ($r = .10, ns$). In contrast, frequency of church attendance was negatively related to risky sexual behavior among Black participants ($r = -.49, p < .01$) but not White participants ($r = -.15, ns$). None of the other correlations were statistically significant. Results are displayed in *Table 4*.

Chapter 4: Discussion

The purpose of this study was to examine the relationship between religiosity and risky behaviors among youths, and to examine how these associations differ between White and Black youths. The results also displayed differences in how frequently Black and White adolescents and young adults participate in religious services and how religiosity is associated with risky behaviors in each racial group. In White participants, the importance of religion to the individual had the greatest negative correlation with substance use. Among Black counterparts, frequency of church attendance was negatively related to risky sexual behavior. The results of this study

provide some new information regarding the racial differences in relationships between religiosity and risky behaviors.

The findings from this study are similar to previously reported associations between religiosity and risky behaviors. For example, numerous studies have found evidence of a negative association between religiosity and engagement in total risky behavior among adolescents (Neighbors, Musick, & Williams, 1998; Lindsey, Brown, & Cunningham, 2017; Wallace et al., 2007). However, the current findings provide more detailed information about how specific aspects of religiosity may differently relate to risky behaviors in various racial groups. Specifically, certain aspects of religiosity related differently to different types of risky behaviors across Black and White youths.

There are numerous studies to support the conceptualization of religious values acting as protective barriers for certain problematic behaviors in certain groups (Wallace et al., 2007; McKoy & Petersen, 2006). Furthermore, current findings regarding relationships between religiosity and risky sexual behaviors specifically in Black individuals aligned with results from other research. Hawes & Berkley-Patton (2014) and McCree et al (2003) found that religiosity had more of an effect for Black participants and served as a stronger protective agent against risky sexual behaviors. Considering the significance of the current findings, further research is essential to assessing additional, qualitative aspects of religiosity and how they correlate with at-risk behaviors as well as assessing the distinct differences in each ethnic group.

The current study has several strengths, such as a racially diverse sample and detailed self-report questionnaires. However, it also has limitations, including the relatively small sample size and the fact that these participants were a unique sample of at-risk youths. As a result, it is

possible that the relationships reported here may not be applicable to all adolescents. Nonetheless, these results contribute to understanding of the relationship between religion and risky behaviors in adolescents. Future research may seek to further understand the connections between religiosity and the likelihood of involvement in risky behaviors. Results from different studies have displayed that involvement in religious services combined with active support systems could help prevent risky behaviors (Neighbors et al., 1998; Hawes & Berkley-Patton, 2014; McCree et al., 2003). Therefore, future studies might look at the effectiveness of interventions delivered through religious groups or settings. Additionally, future directions for this line of research include understanding how mental health stigma may relate to religiosity, how to utilize religious services as sources of information about mental health services, and how interventions and resources can be better tailored for minority communities.

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TABLE 1: *Descriptive Data: Gender, Ethnic Group, and Age of Participants*

	<i>n</i> (%)		
Sex			
Male	64 (83%)		
Female	13 (17%)		
Race			
White	46 (57%)		
Black	34 (43%)		
		<i>SD</i>	<i>M</i>
Age		.742	16.77

TABLE 2: *Results of Chi-square & Crosstab on Race, Religiosity, and Risky Behavior*

	White N (%)	Black N (%)
Considers self religious		
Yes	34 (76%)	23 (74%)
No	11 (24%)	8 (26%)
Attends church 1x/ week or more		
Yes	23 (49%)	24 (75%) *
No	22 (51%)	8 (25%)
Importance of Religion		
Not at all	1 (2%)	3 (9%)
Slightly	6 (13%)	1 (3%)
Somewhat	19 (42%)	9 (28%)
Extremely	19 (42%)	19 (59%)*
Alcohol User		
Yes	40 (89%)	19 (59%)*
No	5 (11%)	13 (41%)
Marijuana User		
Yes	33 (73%)	22 (69%)
No	12 (27%)	10 (31%)
Sexually Active		
Yes	38 (84%)	31 (97%) *
No	7 (16%)	1 (3%)

*Note: *Indicates $p < .01$ group difference*

TABLE 3: *Results of Chi-square Analysis on Race, Religiosity, and Substance Use Behavior*

Ethnicity		Attends church 1x/week or more			Total
			No n (%)	Yes n (%)	
White	Alcohol Use	No	2 (40%)	3 (60%)	5
		Yes	20 (50%)	20 (50%)	40
	Marijuana Use	No	5 (41.7%)	7 (58.3%)	12
		Yes	17(51.5%)	16(48.4%)	33
Black	Alcohol Use	No	4 (30.8%)	9 (69.2%)	13
		Yes	4 (21.1%)	15(78.9%)	19
	Marijuana Use	No	1 (10%)	9 (90%)	10
		Yes	7 (31.8%)	15(68.1%)	22

* *Note: *Indicates $p < .01$*

TABLE 4: *Correlations between Religiosity and Risky Behaviors separately for each race*

Ethnicity	Religiosity	Substances Used Total	Risky Sex Total
White	Religious Self Concept	-.207	.034
	Frequency of Church Attendance	-.208	-.154
	Religious Importance	-.356*	-.139
Black	Religious Self Concept	.050	-.019
	Frequency of Church Attendance	-.032	-.460**
	Religious Importance	.113	-.256

*Note: *Indicates $p < .05$, **indicates $p < .01$*